Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03216

3228

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 7days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale X
STREET ADDRESS (If rural give location) 16 La Vale Street 1

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) L. (Last) Ackerson

4. DATE OF DEATH: (Month) April (Day) 6 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify): Widowed

8. DATE OF BIRTH: 10/21/67

9. AGE last birthday: 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Stone Mason

10B. KIND OF BUSINESS OR INDUSTRY: Construction Self employed

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Ackerson

14. MOTHER'S MAIDEN NAME: Debbora (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Patients Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 week

DUE TO

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) coronary heart disease — 6 months

DUE TO

(C) generalized arteriosclerosis — 1 year

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-3-, 1955, to 4-6-, 1955, that I last saw the deceased alive on 4-6-, 1955, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS 57 Queen St. DATE SIGNED 4-7-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: April 9, 1955 — NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: April 9, 1955 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03217

3229

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.
STREET ADDRESS (If rural give location) 604 Fairview Ave.

3. NAME OF DECEASED: (First) William (Middle) Francis (Last) Appold
4. DATE OF DEATH: (Month) April (Day) 4, (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	5/26/99	55 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman	Queen City Brewing Co.	Maryland Cumberland,	U. S.

13. FATHER'S NAME: William Z. Appold
14. MOTHER'S MAIDEN NAME: Mary E. Stott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No		214-05-4976	Mrs. Cora Appold 604 Fairview Ave., Cumb.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
570.3 IMMEDIATE CAUSE	(A) Generalized peritonitis	6 d.
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Perforation of Sm. bowel (~~Volvulus~~)	6 d
	(C) DUE TO Volvulus	10 d.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Cirrhosis of liver	?

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3-29-55	Volvulus, perfor. of mid. (Sm) bowel.	YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 3/24, 1955 to 4/4, 1955, that I last saw the deceased alive on 4/4, 1955, and that death occurred at 10 25/A M, from the causes and on the date stated above.

SIGNATURE M.D. ADDRESS Cumberland DATE SIGNED 4-4-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/6/55	Rose Hill Cem.	Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 5, 1955	Winter R. Lantz, M.D.	Charles L. George	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03218

3230 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Blvd. Apts. Kelly Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, 02
STREET ADDRESS (If rural give location) 1 Blvd. Apts. Kelly Blvd.

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) ARTHUR (Last) BIXLER

4. DATE OF DEATH: (Month) April (Day) 28, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 27, 1881

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired telegraph oper.

10B. KIND OF BUSINESS OR INDUSTRY: Western Md. Rwy.

11. BIRTHPLACE (State or foreign country): Singers Glen, Va.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Morgan J. Bixler

14. MOTHER'S MAIDEN NAME: Catherine Fulk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No,

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-10-7843-A

17. INFORMANT & ADDRESS: Mrs. Katherine Bixler Blvd. Apts. Cumb.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertension C.V. Disease — years

DUE TO (C) Pernicious Anemia — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1955 to April 28, 1955, that I last saw the deceased alive on April 27, 1955, and that death occurred at about 1 P.M., from the causes and on the date stated above.

SIGNATURE B. M. Schnedler M. D. ADDRESS 41 Fountain, DATE SIGNED 4/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 5/2/55

NAME OF CEMETERY OR CREMATORY S. S. Peter & Pauls Cem.

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR April 29, 1955

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3231

CERTIFICATE OF DEATH

Reg. Dist. No. 03219 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cumberland, rural
STREET ADDRESS (If rural give location) Rt. #2, Baltimore Pike

3. NAME OF DECEASED: (First) Mary (Middle) E. (Last) Bramble

4. DATE OF DEATH: (Month) April (Day) 30 (Year) 1955

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 12/2/77
9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Deceased~~ John T. Bramble
14. MOTHER'S MAIDEN NAME: Eliza Lee ~~Deceased~~
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Pt's chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0
IMMEDIATE CAUSE (A) Generalized Arteriosclerosis — 2 years
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Herpes Zoster — 2 weeks

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-19, 19 55, to 4-30, 19 55, that I last saw the deceased alive on 4-30, 19 55, and that death occurred at 1 P. M, from the causes and on the date stated above.

SIGNATURE Ralph L. Bacon — ADDRESS M. D. Cumberland Md — DATE SIGNED 5-1-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF May 3, 1955 — NAME OF CEMETERY OR CREMATORY Zion Memo. Park. — LOCATION (City, town or county) Cumberland (State) Md

DATE REC'D BY LOCAL REGISTRAR May 2, 1955 — REGISTRAR'S SIGNATURE Winter R. Lantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumb. Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

Within corporate limits

3232

03220

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 4

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 52 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 907 Shades Lane

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN ~~907 Shades Lane~~, Cumberland, Md.
STREET ADDRESS (If rural, give location) 907 Shades Lane

3. NAME OF DECEASED: (Type or Print) (First) Curtis (Middle) Russell (Last) Brant

4. DATE OF DEATH (Month) April (Day) 24 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 7, 1884	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Ret. Mch.	B.&O. Railroad	Flintstone, Maryland	U.S.A.

13. FATHER'S NAME: Helper Henry W. Brant

14. MOTHER'S MAIDEN NAME: Lavina Deihl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	705-05-5247	Mrs. Curtis R. Brant, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (420.1)	(a) Coronary Thrombosis	No interval
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Coronary Artery Disease	—
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Ravages of Age —

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑
—	—	

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
—	—	Cumberland Alley Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
— M.	—	—

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE W. W. Williams M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 4/29/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr. 26, 1955	Trinity Luth. Cem.	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 25, 1955	Wintes R. Bantz, M. D.	John J. Hafer,	Cumberland, Maryland

Within corporate limits

03221

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3233

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND,
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, RT. #1
STREET ADDRESS (If rural give location) X 1

3. NAME OF DECEASED: (First) ~~BABY BOY~~ George (Middle) Randolph (Last) BRANT
4. DATE OF DEATH: (Month) APRIL (Day) 26 (Year) 1955
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH: APRIL 22, 1955
9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND, Cumberland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: GLEN R. BRANT
14. MOTHER'S MAIDEN NAME: SUSAN DIEHL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

770.0
IMMEDIATE CAUSE (A) Erythroblastosis Fetalis
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Rh Neg. Sensitivity
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 4:40A. M, from the causes and on the date stated above.

SIGNATURE Dudley B. Kuhlworth M. D. ADDRESS 23 Bedford St. DATE SIGNED 26 Apr 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 4/26/55
NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REGISTRAR April 26, 1955
REGISTRAR'S SIGNATURE Walter R. Fantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Jr.
ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20452232365
VS. A15—10-53

Dr. Durrett

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3234

03228

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital Memorial Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: Garrett
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Maryland 11X-2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Clark (Middle) C. (Last) Butler

4. DATE OF DEATH: (Month) April (Day) 16, (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single
8. DATE OF BIRTH: March 13 1917
9. AGE last birthday 38 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Odd jobs
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clark C. Butler
14. MOTHER'S MAIDEN NAME: Mary Wilt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-14-7500
17. INFORMANT & ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

353.2
IMMEDIATE CAUSE (A) Status Epilepticus — INTERVAL BETWEEN ONSET AND DEATH: 10 days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cerebral Necrosis — 7 days
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 3, 1955, to Apr 16, 1955, that I last saw the deceased alive on Apr 16, 1955, and that death occurred at 6:00 PM, from the causes and on the date stated above.
SIGNATURE Clay E. Durrett M. D. ADDRESS Cumberland DATE SIGNED 4/18/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF April 19, 1955
NAME OF CEMETERY OR CREMATORY Grantsville Cemetery
LOCATION (City, town, or county) (State) Grantsville, Maryland

DATE REC'D BY LOCAL REGISTRAR April 18, 1955
REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.
24. FUNERAL DIRECTOR Wm Winterberg
ADDRESS Grantsville Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

3282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 03223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 22 Frostburg
LENGTH OF STAY (in this place) 24 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Frostburg 22
STREET ADDRESS (If rural, give location) 248½ Center St.

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) W. (Last) Capel
4. DATE OF DEATH (Month) April (Day) 14 (Year) 19 55
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH: Dec. 2-1885
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Carpenter, laborer, City of Frostburg
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oskaloosa, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Capel
14. MOTHER'S MAIDEN NAME: Eliza Shriver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-10-2437
17. INFORMANT & ADDRESS: Miners Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset And Death
Immediate cause	(a) Acute cardiac dilatation	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Chronic myocarditis with hypertrophy.	?
	DUE TO (c)	

422.2
930

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Impacted fracture of left humerous — 19 days

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF Back yard home INJURY
21c. (City or town) Frostburg (County) Allegany (State) Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 3-24/55-5 P. M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☒
21f. HOW DID INJURY Ooccur? Fell against garage & fractured arm. Walking in back yard

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H. V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 4-15-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 4-17-1955
NAME OF CEMETERY OR CREMATORY F:bg. Memorial Park
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 4-17-55
REGISTRAR'S SIGNATURE Mrs. Nancy N. Poe
24. FUNERAL DIRECTOR ADDRESS Joseph R. Durst. Frostburg, Md.

Within corporate limits DR. W.F. WMS. 03224

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3235 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. 02
LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL 60 MEMORIAL & WARWICK AVENUES

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W.VA. COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PIEDMONT 85X-3
STREET ADDRESS (If rural give location) 87 WEST HAMPSHIRE ✓

3. NAME OF DECEASED: (Type or Print) (First) RICHARD (Middle) A (Last) CAREY

4. DATE OF DEATH: (Month) APRIL (Day) 4 (Year) 55

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED

8. DATE OF BIRTH: 7-2, 1891

9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CASHIER

10B. KIND OF BUSINESS OR INDUSTRY: W.VA. LIQUOR CONTROL COM.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES CAREY

14. MOTHER'S MAIDEN NAME: MARY CAIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

451X

IMMEDIATE CAUSE (A) Dissecting Aneurysm — Less

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arteriosclerosis — Hours 48

DUE TO (C) — Hrs.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-2-, 1955 to 4-4-, 1955 that I last saw the deceased alive on 4-3-, 1955, and that death occurred at 4:45 A.M. from the causes and on the date stated above.

SIGNATURE W.F. Williams M. D. ADDRESS Cumberland DATE SIGNED 4-4-55 MD

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF April 6 1955 — NAME OF CEMETERY OR CREMATORY St. Peters Cemetery — LOCATION (City, town, or county) (State) Westernport, Maryland

DATE REC'D BY LOCAL REGISTRAR April 4, 1955 — REGISTRAR'S SIGNATURE Winter R. Fantz, M.D. — 24. FUNERAL DIRECTOR Bedlock Funeral Home — ADDRESS

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03225

DR. VAN ORMER 3236 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1. PLACE OF DEATH:

COUNTY: ALLEGANY — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND

LENGTH OF STAY (in this place): 1 HR. 55 MIN.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND — COUNTY: ALLEGANY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~LA VALE~~, Near Cumberland, Rural

STREET ADDRESS (If rural give location): R. F. D. #1, LaVale

3. NAME OF DECEASED: (Type or Print) (First) ISABEL (Middle) L ouella (Last) CAWLEY

4. DATE OF DEATH: (Month) APRIL (Day) 28 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	WHITE	MARRIED	MAY 17, 1920	34 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Registered Nurse / HOUSEWIFE	Own Home	PENNSYLVANIA	U.S.A.

13. FATHER'S NAME: CHARLES CHRISTIAN

14. MOTHER'S MAIDEN NAME: ROSE SNYDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Yes	W.W. II	None	MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage, spontaneous — INTERVAL BETWEEN ONSET AND DEATH: 6 hours.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO arterial Hypertension — 8 yrs.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Jan. 4, 19..... to April 28, 19..55, that I last saw the deceased alive on April 26, 19..55, and that death occurred at 3:55A M, from the causes and on the date stated above.

SIGNATURE: W. A. Vanormer M. D. — ADDRESS: Cumberland, Md. — DATE SIGNED: April 29, 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/30/55	St. Mary's Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 29, 1955	Winter R. Lantz M.D.	H. Lee Silcox	Cumberland, Md.

3288

03226

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 15, Film 180 4-22-55 e t

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 9

1. PLACE OF DEATH: Eckhart Mot
COUNTY Alleg MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Parkersburg Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural, give location) Parkersburg Road

3. NAME OF DECEASED: (Type or Print) George (First) Edward (Middle) Coddington, Jr. (Last)

4. DATE OF DEATH (Month) 4- (Day) 18th (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 3/22/1922

9. AGE Last birthday: 33 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Ass't. Mgr.

10b. KIND OF BUSINESS OR INDUSTRY: Credit Co.

11. BIRTHPLACE (State or foreign country): Oakland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George E. Coddington, Sr.

14. MOTHER'S MAIDEN NAME: Mabel V. Wotring

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W. II

16. SOCIAL SECURITY NO.: 215-14-6389

17. INFORMANT & ADDRESS: George E. Coddington, Sr. Oakland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

420.1

Immediate cause (a) Coronary Thrombosis — 4 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) — DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 4/18/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 4/21/55

NAME OF CEMETERY OR CREMATORY Oakland Cemetery

LOCATION (City, town, or county) Oakland, (State) Md.

DATE REC'D BY LOCAL REG. 4-19-55

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR ADDRESS Jacob Hafer, 23 E. Main, Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03227

3237

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 4 dys.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 02 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~La Vale~~ Rural, Cumberland
STREET ADDRESS (If rural give location) R. 7 - D. *1, LaVale

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) C. (Last) Coleman

4. DATE OF DEATH: (Month) April, (Day) 28 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
Male	White	Single	July, 28. 1889	65 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Parking Lot Attendant		Barton, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
August Coleman	Susan Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. If Yes, give war or dates entered service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Yes . World War #1	219 - 14 - 5828	Mrs. Allen Gardner, (Sister) Lonaconing, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE	(A) Coronary Occlusion	6 hours
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (02.12)	DUE TO (B) Congestive Heart Failure	2 mos.
	DUE TO (C) Coronary Heart Disease	1 year.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Secondary Syphilis		?

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 25, 1955, to 28 Apr., 1955, that I last saw the deceased alive on 28 Apr, 1955, and that death occurred at 9:20 AM, from the causes and on the date stated above.

SIGNATURE Garza Richards M. D. ADDRESS Lonaconing, Md. DATE SIGNED 4-28-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May, 1. 1955	Laurel Hill Cemetery	Moscow, Md.

DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 29, 1955	Wintter L. Fantz, M.D.	George Eichhorn,	Lonaconing, Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

Within corporate limits

Stein's

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03228

3238 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany Md. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland
LENGTH OF STAY (in this place) 02
HOSPITAL OR INSTITUTION OR STREET ADDRESS Decatur St. Cumberland, Md. Sacred Heart Hospital,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md. 02
STREET ADDRESS (If rural give location) 532 Green St.

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) (Last) Collins

4. DATE OF DEATH: (Month) April (Day) 17 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: January 26, 1890

9. AGE last birthday 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Elsworth Collins~~ Robert Massey

14. MOTHER'S MAIDEN NAME: Anna Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Sister Mrs. Florence Denson, 532 Green St. City

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 weeks

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertension C.V. Disease (?)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... , 19 .. , to ..... , 19 .. , that I last saw the deceased alive on ..... , 19 .. , and that death occurred at M, from the causes and on the date stated above.

SIGNATURE B. M. Schindler M. D. ADDRESS 41 Bruce St DATE SIGNED 4/18/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 4/19/55

NAME OF CEMETERY OR CREMATORY Sumner Cemetery

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 19, 1955

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03229

3239

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 407 Columbia Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02
STREET ADDRESS (If rural give location) 407 Columbia Street 1

3. NAME OF DECEASED: (Type or Print) (First) Jane (Middle) (Last) Corfield

4. DATE OF DEATH: (Month) April (Day) 16 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 11, 1874

9. AGE last birthday 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Montgomery Brown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. William Brady Daughter Cumberland, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.0 IMMEDIATE CAUSE	(A) Cerebral Embolism	1 Da.
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Phlebothrombosis - Left Leg	7 Da.
	DUE TO (C) Arteriosclerotic Heart Disease	15 Yr.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None

21C. WHERE DID INJURY OCCUR? (City or town) None (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 15, 1954, to April 16, 1955, that I last saw the deceased alive on April 16, 1955, and that death occurred at 8.05 A.M., from the causes and on the date stated above.

SIGNATURE M. D. Vaccinaro MD ADDRESS 146 Bedford St Cumberland, Md. DATE SIGNED 4-16-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | **DATE THEREOF** April 18, 55 | **NAME OF CEMETERY OR CREMATORY** Hillcrest Burial Park | **LOCATION** (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REGISTRAR April 16, 1955 | **REGISTRAR'S SIGNATURE** Winter R. Frantz, M. D.

24. FUNERAL DIRECTOR George Eichhorn **ADDRESS** Lonaconing, Md.

Within corporate limits

Within corporate limits

MARYLAND

STATE DEPARTMETT OF HEALTH

03230

1 3240

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Item 8. FilmG181 5-6-55 et

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 15 Yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Cumberland~~ Bing Gap; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Jennie		Crabtree	April	27	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	W	Siggle	May 1, 1884	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	none	Pine Hills Allegany Co. Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Ross Crabtree	Martha Middleton ~~Crabtree~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No — No	None	Emma Meyers 144 Thomas St., Cumb., Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4427 Immediate cause	(a) Chronic Myocarditis	?
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Nephritis	?
	(c) Cerebral Arteriosclerosis.	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis & Mental Deficiency	15 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. 2 1955 to Apr. 27, 1955 that I last saw the deceased alive on Apr. 26, 1955, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
James E. McLean M.D.	49 Greene St.	4-27-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 29, 1955	Oldtown Cemetery	Oldtown, Maryland

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG.	24. FUNERAL DIRECTOR	ADDRESS
April 26, 1955 Wynter K. Fauntz, M.D.	James F. Scarpelli, Cumberland, "	

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03231

3241 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 3/11/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02
STREET ADDRESS (If rural give location) 212 South Lee Street 1

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Franklin (Last) Cramer

4. DATE OF DEATH: (Month) April (Day) 15, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widower

8. DATE OF BIRTH: 9/10/1871

9. AGE last birthday 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: City Laborer City of Cumberland Street Dept.

11. BIRTHPLACE (State or foreign country): Maryland Sharpsburg

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Cramer

14. MOTHER'S MAIDEN NAME: Mary E. Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Allegany County Infirmary

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE	(A) Coronary Thrombosis	12 hrs.
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Chronic Myocarditis DUE TO	?
	(C) Cerebral Arteriosclerosis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Bronchial Asthma	?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 11th, 1952 to Apr. 14th, 1955, that I last saw the deceased alive on Apr. 13th, 1955, and that death occurred at 2:30 M, from the causes and on the date stated above.

SIGNATURE James E. McLean ADDRESS M.D. 49 Greene St DATE SIGNED 4-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4-18-1955 | NAME OF CEMETERY OR CREMATORY Mountain View Cem. | LOCATION (City, town, or county) (State) Sharpsburg, Md.

DATE REC'D BY LOCAL REGISTRAR April 16, 1955 | REGISTRAR'S SIGNATURE Wintes L. Trantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

Within corporate DR. STEGMAIER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03232

3242 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND — LENGTH OF STAY (in this place) 9 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPTIAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02

STREET ADDRESS (If rural give location) 128 GREENE STREET 1

3. NAME OF DECEASED (Type or Print): (First) EDITH M (Middle) M (Last) CRITES

4. DATE OF DEATH: (Month) APRIL (Day) 21 (Year) 1955

5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED | 8. DATE OF BIRTH: MARCH 4 1910 | 9. AGE last birthday 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10B. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM SWEENEY

14. MOTHER'S MAIDEN NAME: CLARA MARTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-6922

17. INFORMANT & ADDRESS: Clyde Crites, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

171X

IMMEDIATE CAUSE (A) Metastatic Carcinoma — 2 mos.

ANTECEDENT CAUSE (S) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Carcinoma of cervix — 6 mos

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1955, to April, 1955, that I last saw the deceased alive on 21 April, 1955, and that death occurred at 7:06 PM, from the causes and on the date stated above.

SIGNATURE James G. Stegmaier M.D. ADDRESS Cumberland Md, DATE SIGNED 21 April 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | DATE THEREOF: April. 24,1955 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: April 24, 1955 | REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D. | 24. FUNERAL DIRECTOR: Charles L. George, ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

Within corporate limits

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03233

3243 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 40 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 708 Yale Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 708 Yale Street 1

3. NAME OF DECEASED: (Type or Print) (First) Ernest (Middle) R. (Last) Davis

4. DATE OF DEATH (Month) (Day) (Year) April 8, 1955 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Aug. 12, 1914

9. AGE last birthday 40 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: B. & O. RR

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ernest F. Davis

14. MOTHER'S MAIDEN NAME: Nannie P. Brewer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW2

16. SOCIAL SECURITY NO. 214-07-6132

17. INFORMANT & ADDRESS: Marguerite Davis, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

451X
IMMEDIATE CAUSE (A) Dissecting Aneurysm — INTERVAL BETWEEN ONSET AND DEATH Less than 24 hrs

ANTECEDENT CAUSE (S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7-, 1955, to 4-8-, 1955, that I last saw the deceased alive on 4-7-, 1955, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

SIGNATURE W. F. Williams M. D. ADDRESS Cumberland DATE SIGNED 4-8-55 Md

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF April 11, 1955

NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 9, 1955

REGISTRAR'S SIGNATURE Walter L. Trautz, M.D.

24. FUNERAL DIRECTOR ADDRESS William H. Kight, Cumberland, Md.

Mr. Kyle

: 3289 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03234

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lucke
LENGTH OF STAY (in this place) 65 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 325 Pratt St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lake X
STREET ADDRESS (If rural give location) 325 Pratt St

3. NAME OF DECEASED: (Type or Print) (First) Annie (Middle) Elizabeth (Last) Dick

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH: 20 Sept 1867

9. AGE last birthday 87 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Mln. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hancock Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Shoemaker

14. MOTHER'S MAIDEN NAME: Susan Weller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: John Dick, Lake, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 21, 1955, to April 22, 1955, that I last saw the deceased alive on April 22, 1955, and that death occurred at 8:00 A M, from the causes and on the date stated above.

SIGNATURE James H. Workerton Jr. M.D. ADDRESS Piedmont W. Va DATE SIGNED April 23. 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 4-25-55

NAME OF CEMETERY OR CREMATORY Philos Cemetery

LOCATION (City, town, or county) (State) Westernport Md

DATE REC'D BY LOCAL REGISTRAR Apr 25, 1955

REGISTRAR'S SIGNATURE Mrs Jean C. Kelly

24. FUNERAL DIRECTOR E. A. Bard ADDRESS Westernport Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Dr. Mirkin

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03235

3244 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
LENGTH OF STAY (in this place) 138 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital Memorial Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~BARTON, MARYLAND~~, Moscow
STREET ADDRESS (If rural give location) Rt.#1, Easton

3. NAME OF DECEASED: (First) EVERETT (Middle) (Last) DUCKWORTH

4. DATE OF DEATH: (Month) April (Day) 11 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married

8. DATE OF BIRTH: June 13 1879

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) Retired Miner

10B. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harrison Duckworth

14. MOTHER'S MAIDEN NAME: Mary L. Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X
IMMEDIATE CAUSE (A) Carcinoma of prostate — INTERVAL BETWEEN ONSET AND DEATH: one yr.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 12-4-54

19B. MAJOR FINDINGS OF OPERATION: Obstruction of rectum & urethra

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24, 1954, to 4-11-, 1955 that I last saw the deceased alive on 4-11, 1955, and that death occurred at 6:10PM. from the causes and on the date stated above.

SIGNATURE A. Mirkin M.D. ADDRESS Cumberland Md DATE SIGNED 4-12-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF April 14, 1955 | NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | LOCATION (City, town, or county) (State) Moscow, Maryland

DATE REC'D BY LOCAL REGISTRAR April 13, 1955 | REGISTRAR'S SIGNATURE Walter K. Fautz, M.D. | 24. FUNERAL DIRECTOR George Eichhorn | ADDRESS Lonaconing, "

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

Within corporate limits

DR. W F WMS. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03236**

3245 CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND 02
STREET ADDRESS (If rural give location) 805 COLUMBIA AVE. 1

3. NAME OF DECEASED: (Type or Print) (First) LOUIS (Middle) A (Last) FIRLIE

4. DATE OF DEATH: (Month) APRIL (Day) 7 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: SEPT 22, 1887

9. AGE last birthday 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: George Construction Co

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA, New Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph FIRLIE

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-10-8765

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 4 Hrs.

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Generalized Arteriosclerosis — 5 Days

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28, 1955 to 4-7, 1955 that I last saw the deceased alive on 4-7, 1955 and that death occurred at 7:45P M, from the causes and on the date stated above.

SIGNATURE W. F. Williams M. D. ADDRESS Cumberland DATE SIGNED 4-8-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF April 11, 55

NAME OF CEMETERY OR CREMATORY Sts. Peters & Pauls Cem.

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR April 9, 1955

REGISTRAR'S SIGNATURE Walter R. Krantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland, Maryland

Within Corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03237

3246 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, 02
STREET ADDRESS (If rural give location) 112 N. Smallwood St.

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) Coudy (Last) Fisher

4. DATE OF DEATH: (Month) April (Day) 27 (Year) 1955.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: July 17 1881
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Graves
14. MOTHER'S MAIDEN NAME: Harriet Feaga

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Husband G. Walter Fisher, 112 N. Smallwood St.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Occlusion
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic Hypertensive Cardio-
DUE TO
(260X) (C) Vascular Disease
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/26, 1955, to 4/27, 1955, that I last saw the deceased alive on 4/27, 1955, and that death occurred at 5-20 P. M, from the causes and on the date stated above.

SIGNATURE Leo A Key Jr. M. D. ADDRESS 456 N. Centre St. DATE SIGNED 4/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF April 30, 1955
NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 29, 1955
REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George, ADDRESS Cumberland, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3283

03238

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westernport
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 Spruce St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 183 Green St.

3. NAME OF DECEASED: (Type or Print) (First) Hilda (Middle) Madeline (Last) Folk

4. DATE OF DEATH (Month) April (Day) 24 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	June 8, 1908	46 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Twist Tester	Celanese Corp	Westernport, Md	U.S.

13. FATHER'S NAME: James Patrick Sullivan

14. MOTHER'S MAIDEN NAME: Elizabeth Guy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	215-10-8088	Gerald Folk, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
977X Immediate cause	(a) Hemorrhage from Reverend	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) of rt carotid artery	possibly a minute or two
DUE TO	(c) Deficiency of Menstruation	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
—	—	

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
—	—	Westernport Alleg., Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
4-24-55-11 M.		Self inflicted

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE C. H. Williams M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 4/24/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-27-55	Queens Point Cem	Keyser, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-25-55	Mrs. Jean C. Kelly	E. S. Boal	Westernport, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03239

CERTIFICATE OF DEATH

3247

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 02 Cumberland

LENGTH OF STAY (in this place): 50 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00 1101 Lexington Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md. COUNTY: Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland 02

STREET ADDRESS (If rural, give location): 1101 Lexington Ave. 1

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
James	H.	Foreman, Jr.	4	19	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Feb. 5, 1867	88 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Fireman	Tin Mill	Harpers Ferry, W. Va.	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
James H. Foreman	Annie Giddie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No — No	None	Mrs. Margaret Davidson, Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uraemia	3 wks
	DUE TO	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Myocarditis	5 yrs
	DUE TO	
	(c)	

422.2

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Apr. 5, 19 55, to Apr. 22, 19 55, that I last saw the deceased alive on Apr. 18, 19 55, and that death occurred at 5:30 P m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Clay S. Durrett		Cumberland.	4/21/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-22-55	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.:	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 21, 1955	Walter R. Dantz, M.D.	James F. Scarpelli	Cumberland, Md.

Within corporate limits DR. LEY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03240

3248 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 29 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
STREET ADDRESS (If rural give location) 504 PARK STREET 1

3. NAME OF DECEASED: (Type or Print) (First) ARLINGTON (Middle) L. (Last) FOSTER

4. DATE OF DEATH: (Month) APRIL (Day) 19 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED

8. DATE OF BIRTH: OCT. 3 1896

9. AGE last birthday 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never use "retired") Night Watchman

10B. KIND OF BUSINESS OR INDUSTRY: Undergarment Factory

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN FOSTER

14. MOTHER'S MAIDEN NAME: MARY LUDWIG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) W.W.I

16. SOCIAL SECURITY NO. 220-10-2583

17. INFORMANT & ADDRESS: Rennert Memorial Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1 (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S): DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive Cardio-Vascular Disease DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pneumonia

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/21, 1955, to 4/19, 1955, that I last saw the deceased alive on 4/17, 1955, and that death occurred at 9:10 AM from the causes and on the date stated above.

SIGNATURE Leo N. Ley Jr. M. D. ADDRESS 456 N. Centre St. DATE SIGNED 4/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 4/21/55 — NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery — LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REGISTRAR April 20, 1955 — REGISTRAR'S SIGNATURE Winter R. Manly, M.D.

24. FUNERAL DIRECTOR Lucio Steen Inc — ADDRESS Cumberland Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Write correct Name Dr. Simons

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03241

3249 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. 02
LENGTH OF STAY (in this place) 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital Memorial Avenue 60

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND 02
STREET ADDRESS (If rural give location) 437 Ascension St., 1

3. NAME OF DECEASED: (Type or Print) (First) LILLIAN (Middle) L. (Last) GATES

4. DATE OF DEATH: (Month) APRIL (Day) 11 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed

8. DATE OF BIRTH: July 16, 1878

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Don't if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Washington County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: James R. Norris

14. MOTHER'S MAIDEN NAME: Mary Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X IMMEDIATE CAUSE (A) Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH 2 year

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/30, 1955 to 4/11, 1955, that I last saw the deceased alive on 4/11, 1955, and that death occurred at 10:28 P.M., from the causes and on the date stated above.

SIGNATURE George M Brown M. D. ADDRESS Cumberland Md DATE SIGNED 4/13/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4/14/55 | NAME OF CEMETERY OR CREMATORY Greemount Cemetery | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 13, 1955 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03242

DR. HALLINAN 3250 CERTIFICATE OF DEATH Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 201 SPRING STREET

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) C. (Last) GORDON

4. DATE OF DEATH: (Month) APRIL (Day) 17, (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: FEBRUARY 5, 1906

9. AGE last birthday 49 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARMAN HELPER

10B. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.CO.

11. BIRTHPLACE (State or foreign country): MARYLAND, Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CLIFFORD GORDON

14. MOTHER'S MAIDEN NAME: MARGARET WEISENMILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-07-9668

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1 — (A) DUE TO Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 7 Da.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Coronary Heart Disease — 7 Mo.

(C) none

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none

21C. WHERE DID INJURY OCCUR? (City or town) none (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. none

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 16, 1955, to April 17, 1955, that I last saw the deceased alive on 4-17, 1955, and that death occurred at 3:30 A M, from the causes and on the date stated above.

SIGNATURE J. L. Hallinan M.D. ADDRESS 140 Bedford St. Cumberland Md. DATE SIGNED 4-18-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Apr. 20, 1955 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) Cumberland (State) Maryland

DATE REC'D BY LOCAL REGISTRAR April 20, 1955 — REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer — ADDRESS Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03243**

CERTIFICATE OF DEATH

3251 Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 1 hr. 10 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pennsylvania COUNTY Bedford
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bedford Valley
STREET ADDRESS (If rural give location) Route #3

3. NAME OF DECEASED: (Type or Print) (First) David (Middle) M. (Last) Growden

4. DATE OF DEATH: (Month) 4-24-55 (Day) (Year) 19

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single
8. DATE OF BIRTH: 1-24-54
9. AGE last birthday [illegible] yrs. IF UNDER 1 YEAR: Months 3 Days; IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa. Centreville
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alvin Growden
14. MOTHER'S MAIDEN NAME: Pearl Bosley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Chart Sacred Ht. Hosp. Cumberland md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Waterhouse-Friderichsen syndrome 12 hrs

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? 5:10 PM - 6:30 PM

22. I hereby certify that I attended the deceased from 4/24, 19 55, to 4/24, 19 55, that I last saw the deceased alive on 4/24, 19 55, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

SIGNATURE Elizabeth Growden M. D. ADDRESS 55 Greene St. DATE SIGNED 4/25/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Apr. 26. 1955
NAME OF CEMETERY OR CREMATORY Fellowship Cemetery
LOCATION (City, town, or county) (State) Centreville, Bedford Co. Pa

DATE REC'D BY LOCAL REGISTRAR April 26, 1955
REGISTRAR'S SIGNATURE Walter R. Frantz, M. D.
24. FUNERAL DIRECTOR John J. Hafer. ADDRESS Cumberland, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03244

3290

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing
LENGTH OF STAY (in this place) 80yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Charlestown Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing X
STREET ADDRESS (If rural give location) Charlestown Street 1

3. NAME OF DECEASED: (Type or Print) (First) DRUIE (Middle) (Last) HACKER

4. DATE OF DEATH: (Month) April, (Day) 9th (Year) 55 19

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed
8. DATE OF BIRTH: Feb, 21. 1875
9. AGE last birthday 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Moses
14. MOTHER'S MAIDEN NAME: Rebecca Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: MRS. Thomas Clark, (Daughter) Lonaconing, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 420.1	(A) Coronary Occlusion	2d.
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Coronary Heart Disease	1 yrs
	DUE TO (C) Arteriosclerosis	5 yr.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/28, 19 55, to 4/9, 19 55, that I last saw the deceased alive on 4/9, 19 55, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE S. Richards M.D.
ADDRESS Lonaconing Md
DATE SIGNED 4-11-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF April, 12. 55
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) (State) Lonaconing, MD.

DATE REC'D BY LOCAL REGISTRAR 4-12-55
REGISTRAR'S SIGNATURE Jeanette M Boal
24. FUNERAL DIRECTOR George Eichhorn, ADDRESS Lonaconing, MD.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03245

3252

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 29da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat Furnace Ext.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 950 Gay St.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Charles Brace Hickle

4. DATE OF DEATH: (Month) (Day) (Year) 4 22 1955

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: 5 17 1881

9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY: W.M. Lumber Co,

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Hickle

14. MOTHER'S MAIDEN NAME: Susan Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs Minnie Hickle, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Cerebral arteriosclerosis — ?

DUE TO (C) Osteo-arthritis (Deforming), — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Alcoholic psychosis — ?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 25, 1955, to Apr. 22, 1955, that I last saw the deceased alive on Apr. 22 1955, and that death occurred at 12 P. M, from the causes and on the date stated above.

SIGNATURE James B. McLean M. D. ADDRESS 79 Grant St. DATE SIGNED 4-23-55.

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial

DATE THEREOF April 25 1955

NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park

LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR April 24, 1955

REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

3253

03246

Items 18&21 Film G182 5-27-55 wmk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 02 Cumberland
LENGTH OF STAY (In this place) Eight Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural, give location) 215 W. Oldtown Road

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) Timberlake (Last) Holland
4. DATE OF DEATH (Month) 4 (Day) 22 (Year) 1955
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Sept 18 1876
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Wva Pulp & Paper Co
11. BIRTHPLACE (State or foreign country): Winchester, Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William A. Holland
14. MOTHER'S MAIDEN NAME: Margaret Baylis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-07-9408
17. INFORMANT & ADDRESS: Mrs. C.M. Holland, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
970.2 Immediate cause	(a) Not determined (illegible)	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) BARBITURIC ACID POISONING	' HRS.
	DUE TO (c) (illegible) (SUICIDE)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Myocardial degeneration -ACVD- Cerebral arterio-sclerosis Chronic Nephritis terminal state

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY
21c. (City or town) Cumberland (County) Alleg (State) Md
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐ Undetermined cause ☐.

SIGNATURE (illegible) M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 4/25/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF April 25 1955
NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. April 24, 1955
REGISTRAR'S SIGNATURE Arnita R. Lantz, M.D.
24. FUNERAL DIRECTOR William H. Kight, Cumberland, ADDRESS Md.

[redacted]

Within corporate limits

3254 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03247

DR. W.F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
LENGTH OF STAY (in this place) 38 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital or institution, give street address or location) MEMORIAL HOSPITAL 60

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE PENNSYLVANIA COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD 75 x-3
STREET ADDRESS (If rural give location) BOX 432 605 S. Richards, St

3. NAME OF DECEASED: (Type or Print) (First) RUTH (Middle) A (Last) HOLSOPPLE

4. DATE OF DEATH: (Month) APRIL (Day) 10 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): DIVORCED

8. DATE OF BIRTH: SEPTEMBER 22, 1917

9. AGE last birthday 37 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DIETICIAN

10B. KIND OF BUSINESS OR INDUSTRY: BEDFORD MEMORIAL HOSP.

11. BIRTHPLACE (State or foreign country): BEDFORD, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: IRA L. FOREMAN

14. MOTHER'S MAIDEN NAME: CORA C. DIBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 205-01-9626

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X
IMMEDIATE CAUSE (A) Carcinomatosis thoracic Cavity — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Carcinoma rt. breast — Dec '53
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: Dec '53

19B. MAJOR FINDINGS OF OPERATION: Carcinoma rt. breast.

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-7-, 1955, to 4-10, 1955, that I last saw the deceased alive on 4-9-, 1955, and that death occurred at 12:15 A M, from the causes and on the date stated above.

SIGNATURE W.F. Williams M. D. ADDRESS Cumberland DATE SIGNED 4-10-55 MD

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4/13/55 | NAME OF CEMETERY OR CREMATORY Bedford Memorial Cem. | LOCATION (City, town, or county) (State) Bedford Penna.

DATE REC'D BY LOCAL REGISTRAR April 11, 1955 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS Louis Geisel - Bedford, Penna.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Lamb

3291 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (0)3248

CERTIFICATE OF DEATH

Reg. Dist. No. 9

Item 8, Film 181 5-9-55 et

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. No 1 Frostburg, Md

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) R. D. No 1 Frostburg, Md

3. NAME OF DECEASED: (Type or Print) (First) Goldie (Middle) E. (Last) Scott

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single | 8. DATE OF BIRTH: Aug 3 1907 | 9. AGE last birthday 47 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework | 10B. KIND OF BUSINESS OR INDUSTRY: Own home | 11. BIRTHPLACE (State or foreign country): Cumberland, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Archie B. Scott | 14. MOTHER'S MAIDEN NAME: Edith Stephenson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS: Frostburg, Md. Mrs Archie Scott (mother)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

353.3
IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Epilepsy, severe — since birth
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21, 1955, to 4/22, 1955, that I last saw the deceased alive on 4/21, 1955, and that death occurred at 5:55 AM, from the causes and on the date stated above.

SIGNATURE John B. Davis, M. D. ADDRESS Frostburg, Md. DATE SIGNED 4/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4-24-1955 | NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park | LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 4-28-55 | REGISTRAR'S SIGNATURE M. Nancy N. Pile | 24. FUNERAL DIRECTOR Jacob Taper | ADDRESS Frostburg, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits WRIGHTMEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03249

3255 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
02
LENGTH OF STAY (in this place) 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
STREET ADDRESS (If rural give location) 31 WEBER ST. 1

3. NAME OF DECEASED: (Type or Print) (First) HAROLD (Middle) Jay (Last) HOWARD

4. DATE OF DEATH: (Month) APRIL (Day) 17 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: JULY 17 1883

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired R.R. Postal Clerk

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VERMONT

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE HOWARD

14. MOTHER'S MAIDEN NAME: LUELLA CARPENTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 422.1

(A) Acute Anterior Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 54, to April 55, that I last saw the deceased alive on April 16, 1955, and that death occurred at 10:05AM from the causes and on the date stated above.

SIGNATURE S. Benton Hemmelwright M.D. ADDRESS 133 Va. Ave. Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4/20/55 | NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 18, 1955 | REGISTRAR'S SIGNATURE Wintes R. Trantz, M.D.

24. FUNERAL DIRECTOR H. Lee Silcox ADDRESS Cumberland, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03250

3256 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany COUNTY — MARYLAND STATE
   CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
   LENGTH OF STAY (in this place): I wk
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland STATE — Allengany COUNTY
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland 02
   STREET ADDRESS (If rural give location): 432 Grand Avenue 1

3. NAME OF DECEASED: (First) Mary (Middle) Ellen (Last) Joyce

4. DATE OF DEATH: (Month) April (Day) 28 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 2-22-05

9. AGE last birthday: 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas F. Joyce

14. MOTHER'S MAIDEN NAME: Ellen Rowan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Self Paul Joyce 432 Grand Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

414X

IMMEDIATE CAUSE (A) Congestive Cent failure — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Chronic valvular Heart disease, Rheumatic — 3 years?

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 Apr. 55, 19..., to 28 Apr., 1955, that I last saw the deceased alive on 28 Apr. 55, 19..., and that death occurred at 8 P. M, from the causes and on the date stated above.

SIGNATURE: W. A. Van Orne M. D. — ADDRESS: Cumberland, Md. — DATE SIGNED: 30 Apr. 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 5-2-55 — NAME OF CEMETERY OR CREMATORY: St. Partick Cem. — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: April 30, 1955 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md

Scarpelli No. Cumberland

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

Within corporate limits

Dr. Joaquelli

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03251

3257 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02
LENGTH OF STAY (in this place) 24 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 911 Louisanna Ave. 1

3. NAME OF DECEASED: (Type or Print) (First) Hallie (Middle) Pattie (Last) Kesler

4. DATE OF DEATH: (Month) April (Day) 30, (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 10, 1889

9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Willowton, W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis H. Davis

14. MOTHER'S MAIDEN NAME: Lillie B. Crowford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Pts Chart Ella Twigg 911 La. Ave

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
430.0 IMMEDIATE CAUSE	(A) Arterial Embolism (Femoral)	24 h
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Vegetative Heart disease	2 yrs.
	DUE TO (C) endocarditis	?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 4.29.55

19B. MAJOR FINDINGS OF OPERATION Femoral artery embolism

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4.29.55, 19..... to 4.30.55, 19....., that I last saw the deceased alive on 4.30.55, 19....., and that death occurred at 3:19 P. M, from the causes and on the date stated above.

SIGNATURE C. C. Zimmerman M. D. ADDRESS Cumberland Md. DATE SIGNED 5.1.55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 5-4-55

NAME OF CEMETERY OR CREMATORY St Peter and Paul Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR May 2, 1955

REGISTRAR'S SIGNATURE Walter R. Frantz, M. D.

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland, M

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03252

3258 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, 02
STREET ADDRESS (If rural give location) 79 Greene St., 1

3. NAME OF DECEASED: (Type or Print) (First) APPOLLONIA (Middle) (Last) KRAFT

4. DATE OF DEATH: (Month) April (Day) 23, (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: July 22, 1869

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Andrew Kraft

14. MOTHER'S MAIDEN NAME: Sarah Ann Guthman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Miss Anna Kraft 79 Greene St., Cumb. Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 4428X (A) Hypertensive Cardio Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH 6 years

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-31, 1949 to 4-23, 1955 that I last saw the deceased alive on 4-22, 1955, and that death occurred at 4:30 M, from the causes and on the date stated above.

SIGNATURE W. K. Williams M. D. ADDRESS Cumberland DATE SIGNED 4-25-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4/26/55 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 26, 1955 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

03253

MARYLAND

STATE DEPARTMETT OF HEALTH

3259

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS 434 Pennsylvania Ave,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 434 Pennsylvania Avenue

3. NAME OF DECEASED (Type or Print) (First) Eva (Middle) Bell (Last) Lapp

4. DATE OF DEATH (Month) (Day) (Year) Apr. 18, 1955

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH June 8, 1882

9. AGE last birthday 72 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew T. McLuckie

14. MOTHER'S MAIDEN NAME Alice Larue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Mrs. Wm. Yates, Cumberland, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: About 12 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1940, to Apr. 18, 1955, that I last saw the deceased alive on 4-18-, 1955, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

SIGNATURE W. L. Williams (Degree or title) ADDRESS Cumberland DATE SIGNED 4-19-55

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE April 21, 1955

NAME OF CEMETERY OR CREMATORY Hillcrest Bur. Park

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. April 21, 1955

REGISTRAR'S SIGNATURE Wirtes K. Bauby, M.D.

24. FUNERAL DIRECTOR John J. Hafer

ADDRESS Cumberland, Maryland

MARGIN RESERVED FOR BINDING

3284

03254

Reg. Dist. 9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 6 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 118 McCollough St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 104 East First St.

3. NAME OF DECEASED: (Type or Print) (First) Hettie (Middle) (Last) MacDonald

4. DATE OF DEATH (Month) April (Day) 9 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Nov. 11-1870

9. AGE last birthday: 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Practical Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Private Homes

11. BIRTHPLACE (State or foreign country): Barton, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Phillip Keyes

14. MOTHER'S MAIDEN NAME: Elizabeth Warnick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 314-32-7339

17. INFORMANT & ADDRESS: MacDonald (daughter) Myrtle McDonald, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.2

Immediate cause (a) Acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Chronic myocarditis with hypertrophy — several years.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H. V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED April-11-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 4-12-55

NAME OF CEMETERY OR CREMATORY Rose Hill Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 12, 1955

REGISTRAR'S SIGNATURE Mrs. Nancy N. Rae

4-13-55

24. FUNERAL DIRECTOR James F. Scarpelli

ADDRESS Cumberland, Md.

Scarpelli

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03255

3260 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 2yrs.4m.10da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS IX Sylvan Retreat Furnace Ext.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02 1
STREET ADDRESS (If rural give location) 360 Frederick St.

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) E. (Last) Mankamyer

4. DATE OF DEATH: (Month) 4 (Day) 22 (Year) 1955

5. SEX: F. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W. | 8. DATE OF BIRTH: June 9 1877 | 9. AGE last birthday 77 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own House
11. BIRTHPLACE (State or foreign country): Glencoe, Somerset Co, Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Martz
14. MOTHER'S MAIDEN NAME: Sarah Shoemaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Mrs. Elsie Sims, Cleveland, Ohio

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422,1 IMMEDIATE CAUSE	(A) Chronic Myocarditis,	?
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Cerebral Arteriosclerosis,	?
	DUE TO (C) Senility	2 mos.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Senile psychosis & Depression	3 yrs.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 12, 1955, to Apr. 22 1955, that I last saw the deceased alive on Apr. 22 1955, and that death occurred at 5.15 P M, from the causes and on the date stated above.

SIGNATURE James E. McLean M. D. ADDRESS 49 Greene St. DATE SIGNED 4-23-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF April 25 1955 | NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | LOCATION (City, town, or county) (State) Sand Patch, Somerset Co Pa.

DATE REC'D BY LOCAL REGISTRAR April 24, 1955 | REGISTRAR'S SIGNATURE Wirtz L. Martz, M. D. | 24. FUNERAL DIRECTOR William H. Kight | ADDRESS Cumberland, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03256

DR. FAW 3261 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
LENGTH OF STAY (in this place) 8 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE PENNA. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD, Rural
STREET ADDRESS (If rural give location) RT. #3

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) FLORIBEL Gray MARKWOOD

4. DATE OF DEATH: (Month) (Day) (Year) 4-24 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED
8. DATE OF BIRTH: 6-5-1905
9. AGE last birthday 49 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Lancaster, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM E. GRAY
14. MOTHER'S MAIDEN NAME: IDA M. DIBBLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Carcinoma of ovary bilateral — INTERVAL BETWEEN ONSET AND DEATH: Appx 2 yrs.
DUE TO with
(B) metastasis to the liver — Appx 1 yr.
DUE TO
(C) Terminal cachexia — 3 months.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: Nov 1, 1954
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of ovary bilateral
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 26, 1954 to Apr 24, 1955, that I last saw the deceased alive on Apr 24, 1955, and that death occurred at 4:40 P M, from the causes and on the date stated above.
SIGNATURE T. W. Faw Jr M. D. ADDRESS Cumberland DATE SIGNED Md.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 4/27/55
NAME OF CEMETERY OR CREMATORY Mt. Rose Hill Cem.
LOCATION (City, town, or county) (State) Coply Twn. Akron Ohio

DATE REC'D BY LOCAL REGISTRAR April 25, 1955
REGISTRAR'S SIGNATURE Walter R. Faw, M.D.
24. FUNERAL DIRECTOR ADDRESS Louis Geisel - Bedford, Penna.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03257

3262 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md. 02
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS In front of Home 217 Race St. 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md. 02
STREET ADDRESS (If rural give location) 217 Race St. 1

3. NAME OF DECEASED: (Type or Print) (First) Francis (Middle) Basil (Last) Moreland

4. DATE OF DEATH: (Month) April (Day) 12, (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Aug. 26, 1881

9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocery Store

10B. KIND OF BUSINESS OR INDUSTRY: Own Business

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Moreland

14. MOTHER'S MAIDEN NAME: Mary Shatzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-32-3272

17. INFORMANT & ADDRESS: Francis B. Moreland Cumberland, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
IMMEDIATE CAUSE (A) Cardiac arrest — Immediate

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertensive Heart Disease with Congestive failure. — 2 years

DUE TO (C) arterial hypertension — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Sept., 1954, to 12 Apr., 1955, that I last saw the deceased alive on 11 Apr., 1955, and that death occurred at 4:35 A.M., from the causes and on the date stated above.

SIGNATURE W. D. V. Ames M. D. ADDRESS Cumberland, Md. DATE SIGNED 13 Apr. 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4-15-55 | NAME OF CEMETERY OR CREMATORY St Mary's Cem. | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 14, 1955 | REGISTRAR'S SIGNATURE Walter R. Tantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

3292 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03258

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing
LENGTH OF STAY (in this place) 63 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Church Street

2. USUAL RESIDENCE (HOME) OF DECEASED. STATE MD. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing X
STREET ADDRESS (If rural give location) 1 Church Street

3. NAME OF DECEASED: (Type or Print) (First) CATHERINE (Middle) (Last) MURPHY

4. DATE OF DEATH: (Month) April/6th. (Day) (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH: Jan, 8th. 1892
9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cornelius Murphy
14. MOTHER'S MAIDEN NAME: Mary Farrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Margaret Murphy (SISTER) Lonaconing, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 420.0	(A) Coronary Occlusion	2 hrs
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Congestive Heart Failure.	4-5 mo
	DUE TO	
	(C) Arteriosclerotic Heart Disease	1-2 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1953 to 6 April, 1955, that I last saw the deceased alive on 6 April, 1955, and that death occurred at 6a M, from the causes and on the date stated above.

SIGNATURE ☆ Richards M.D. ADDRESS Lonaconing, Md DATE SIGNED 5/7/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF April 9
NAME OF CEMETERY OR CREMATORY St. Marys Cemetery
LOCATION (City, town, or county) (State) Lonaconing, MD.

DATE REC'D BY LOCAL REGISTRAR 4/9-55
REGISTRAR'S SIGNATURE Jannette M Bond
24. FUNERAL DIRECTOR ADDRESS George Eichhorn, Lonaconing, MD.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3263

CERTIFICATE OF DEATH

03250

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany County MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md
LENGTH OF STAY (in this place) 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Alleg.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing, Md. X
STREET ADDRESS (If rural give location) 33 West Main St. 1

3. NAME OF DECEASED: (Type or Print) (First) Mary Alice (Middle) (Last) Neff

4. DATE OF DEATH: (Month) (Day) (Year) 4-2-55 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: 8-8-80

9. AGE last birthday 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William E. Clapp

14. MOTHER'S MAIDEN NAME: Ella Hedrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Miss Mary Neff (Daughter)

18. MEDICAL CERTIFICATION Lonaconing, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
IMMEDIATE CAUSE (A) Congestive Heart Failure — 4 mos.
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic Heart Disease — 1-2 yrs.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1954, to 4-2, 1955, that I last saw the deceased alive on 4-2, 1955, and that death occurred at 8.55 P M, from the causes and on the date stated above.

SIGNATURE J. Richards M. D. ADDRESS Lonaconing DATE SIGNED 4-4-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF April 5. 1955 | NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | LOCATION (City, town, or county) (State) Lonaconing, Md

DATE REC'D BY LOCAL REGISTRAR April 5, 1955 | REGISTRAR'S SIGNATURE Winter R. Beauty, M.D.

24. FUNERAL DIRECTOR ADDRESS George Eichhorn, Lonaconing, MD

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

3264

03260

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 02 Cumberland

LENGTH OF STAY (in this place) 30 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 1 Miltenburger Place

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland 02

STREET ADDRESS (If rural, give location) 1 Miltenburger Place

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	William	Randalls	April	7	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	Sept. 24-1885	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Blacksmith	B&O.R.Ry.	Keyser, W.Va.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Benjamin Randalls	Mary Sue Corbin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	705-05-4664	(wife) Minnie Ellsworth Randalls, City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
540.0 Immediate cause	(a)	Asthenia	7 months
	DUE TO		
Antecedent cause(s)	(b)	Malnutrition	gradual
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO	Anorexia	3 weeks
	(c)	Chronic gastric ulcer.	?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H. V. Deming M. D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED April 7-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/11/1955	Rose Memorial Burial Park	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 9, 1955	Walter K. Bantz M.D.	William H. Kight	Cumberland Md

Kight

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03261

3265 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 333 MT. VIEW DRIVE

3. NAME OF DECEASED: (First) CHARLES (Middle) W (Last) RAYGOR

4. DATE OF DEATH: (Month) APRIL (Day) 18 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: MARCH 26, 1877

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired): Retired Conductor

10B. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Avilton Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: OLIVER RAYGOR

14. MOTHER'S MAIDEN NAME: MARY C BITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs. Vincent Bargman (Daughter) City

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X IMMEDIATE CAUSE (A) Chronic Nephritis with uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO arteriosclerosis

(C) Diabetes mellitus

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8-, 1955, to 4-18, 1955, that I last saw the deceased alive on 4-18-, 1955 and that death occurred at 8:58P M, from the causes and on the date stated above.

SIGNATURE Howard L Tolson M. D. ADDRESS Cumberland Md. DATE SIGNED 4-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4-21-55 | NAME OF CEMETERY OR CREMATORY St. Marys Cem. | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 21, 1955 | REGISTRAR'S SIGNATURE Wintter R. Hauch, M.D.

24. FUNERAL DIRECTOR ADDRESS James F. Sarpelli, Cumberland, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

3285

2411 N. Charles Street, Baltimore

03262

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 22 Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland X
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Ann (Last) Retallic
4. DATE OF DEATH: (Month) April (Day) 6 (Year) 19 55

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July, 25. 1873
9. AGE last birthday: 81 yrs. — If under 1 year: Months. Days. — If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Midland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Toll
14. MOTHER'S MAIDEN NAME: ------ Stevenson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Isabella Morgan (Daughter) Midland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

156.1 Immediate cause (a) ADVANCED CARCINOMA OF LIVER — ??-

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE
19b. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ✓ — (CITY OR TOWN): ✓ — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ✓
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from 3/30, 1955, to 4/6, 1955, that I last saw the deceased alive on 4/6, 1955, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Martin Weinstein M.D. — 48 Broadway - Frostburg Md. — 4/7/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: April, 9. 55
NAME OF CEMETERY OR CREMATORY: Memorial Park
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 4-9-55
REGISTRAR'S SIGNATURE: Mrs. Nancy A. Roe
24. FUNERAL DIRECTOR — ADDRESS: George Eichhorn, Lonaconing, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03268

3266 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 4 yr. 4m. 18da.
02
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat Furnace Ext.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 236 Williams St. 1

3. NAME OF DECEASED: (First) Emma (Middle) (Last) Rexrode
4. DATE OF DEATH: (Month) 4 (Day) 22 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F.	W.	W.	Oct. 12, 1877	77 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Fairmont, West Virginia	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Rollins	Emma Wear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No	None	Mrs. Jas. W. Duffey, Baltimore, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 IMMEDIATE CAUSE	(A) Pulmonary hypostasis	
ANTECEDENT CAUSE (S) DUE TO	(B) Chronic myocarditis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(C) Cerebral arteriosclerosis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Senile psychosis paranoid	5 yrs.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1952 to Apr. 22 1955 that I last saw the deceased alive on Apr. 22 1955, and that death occurred at 2 P M, from the causes and on the date stated above.

SIGNATURE James E. McLean M. D. ADDRESS 49 Greene St DATE SIGNED 4-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr. 25, 1955	Camp Hill Cemetery	Paw Paw, West Virginia

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 25, 1955	Walter R. Frantz, M.D.	John J. Hafer, Cumberland,	Maryland

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03264

3267 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 5 HRS. 20 MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY ALLEG.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 403 CENTRAL AVENUE

3. NAME OF DECEASED: (Type or Print) (First) BABY GIRL (Middle) (Last) RICE #1

4. DATE OF DEATH: (Month) APR. (Day) 24 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH: APR. 24, 1955

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 5 Min. 20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD. Cumberland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RONALD RICE

14. MOTHER'S MAIDEN NAME: BARBARA COOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
776X IMMEDIATE CAUSE	(A) Prematurity (5 mon. twin)	
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/24, 1955 to 4/24, 1955 that I last saw the deceased alive on 4/24, 1955, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

SIGNATURE W. Royce Hodges M. D. ADDRESS Cumberland, Md DATE SIGNED 4/25/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4-26-55 | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 26, 1955 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1

2145182180

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03265

3268 CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

2145183180

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 5 HRS. 10 MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY ALLEG.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
STREET ADDRESS (If rural give location) 403 CENTRAL AVENUE

3. NAME OF DECEASED: (First) BABY GIRL (Middle) (Last) RICE #2

4. DATE OF DEATH: (Month) APRIL 24 (Day) (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: APR. 24, 1955

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 5 Min. 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD. Cumberland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RONALD RICE

14. MOTHER'S MAIDEN NAME: BARBARA COOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 776X (A) Prematurity (5 mon. twin) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/24, 1955 to 4/24, 1955, that I last saw the deceased alive on 4/24, 1955, and that death occurred at 11:25 P.M. from the causes and on the date stated above.

SIGNATURE W. Royce Hodges M. D. ADDRESS Cumberland, Md. DATE SIGNED 4/25/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 4-26-55 — NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 26, 1955 — REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03266

CERTIFICATE OF DEATH

Reg. Dist. No. 4

3269

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 417 Winmer St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 417 Winmer St.

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) ALEXANDER (Last) RILEY

4. DATE OF DEATH: (Month) April (Day) 14 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 12, 1864
9. AGE last birthday: 90 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Laban Riley
14. MOTHER'S MAIDEN NAME: Caroline Hager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Mrs. Joseph Taylor, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.1
IMMEDIATE CAUSE (A) Coronary Thrombosis & Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arteriosclerosis
DUE TO (C) Ravages of Age

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/17/52, 19..., to 4/14/55, 19..., that I last saw the deceased alive on 4/14/55, 19..., and that death occurred at 4:40, M., from the causes and on the date stated above.

SIGNATURE W. H. Williams M. D. ADDRESS Cumberland DATE SIGNED 4/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: April 17, 1955
NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery
LOCATION (City, town, or county) (State): Fort Ashby, W. Va.

DATE REC'D BY LOCAL REGISTRAR: April 16, 1955
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR ADDRESS: Charles L. George, Cumberland, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Mr. Lurie

Within corporate limits

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03267

Reg. Dist. No. 1

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.
LENGTH OF STAY (in this place) 1 Day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural give location) 7 Offutt St.

3. NAME OF DECEASED: (Type or Print) (First) Baby (Middle) Girl (Last) Ruppenkamp

4. DATE OF DEATH: (Month) April (Day) 26 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: April 25, 1955

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days 1 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John R. Ruppenkamp

14. MOTHER'S MAIDEN NAME: Catherine D. Sharon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 IMMEDIATE CAUSE (A) Atelectasis DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 32 hrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Prematurity

19A. DATE OF OPERATION: [redacted]

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 April, 1955 to 26 April, 1955, that I last saw the deceased alive on 26 April, 1955, and that death occurred at 4:55 P.M. from the causes and on the date stated above.

SIGNATURE Leland A. Carson M.D. ADDRESS 63 Greene St Cumberland DATE SIGNED 26 April 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF April 27, 1955 | NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | LOCATION (City, town, or county) Cumberland, (State) Maryland

DATE RECD BY LOCAL REGISTRAR April 27, 1955 | REGISTRAR'S SIGNATURE Walter K. Trautz, M.D. | 24. FUNERAL DIRECTOR James F. Scarpelli | ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

20452/12402

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03268

3271

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 2 days
02
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 501 Warren St. 1

3. NAME OF DECEASED: (Type or Print) (First) Peter (Middle) (Last) Santora

4. DATE OF DEATH: (Month) (Day) (Year) 4/24/55 19

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married
8. DATE OF BIRTH: 6-29-78
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Italy, Ascoli-Satriano
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Andrew Santora
14. MOTHER'S MAIDEN NAME: Mary Jo Salatta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-5833
17. INFORMANT & ADDRESS: Mr. Andrew F. Santora Balto. Pike, Cumb.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic Heart Disease — 2 years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-8, 1954, to 4-24, 1955, that I last saw the deceased alive on 4-24, 1955, and that death occurred at 3:10 P.M., from the causes and on the date stated above.
SIGNATURE Ralph W. Barnes M. D. ADDRESS Cumberland Md DATE SIGNED 4-25-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 4/27/55
NAME OF CEMETERY OR CREMATORY S. S. Peter & Pauls Cem.
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE RECD BY LOCAL REGISTRAR April 26, 1955
REGISTRAR'S SIGNATURE Winter R. Sanky M.D.
24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03269

3286

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 1, Frostburg X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) H. (Last) Scott

4. DATE OF DEATH (Month) (Day) (Year) April 30th, 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widower

8. DATE OF BIRTH: August 7th, 1879

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shell line-retired

10B. KIND OF BUSINESS OR INDUSTRY: Kelly-Springfield

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Scott

14. MOTHER'S MAIDEN NAME: Jane Nicols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-9909

17. INFORMANT & ADDRESS: Percy Scott, Route 1, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Cardio. vascular Renal disease — Several Years.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1953, to April 30, 1955, that I last saw the deceased alive on April 30, 1955, and that death occurred at 1 30/A M, from the causes and on the date stated above.

SIGNATURE John B. Davis, M.D. M.D. ADDRESS Frostburg, Md DATE SIGNED 5/2/55.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF May 2nd, 55 | NAME OF CEMETERY OR CREMATORY Vale Summit Cemetery | LOCATION (City, town, or county) (State) Vale Summit, Md.

DATE REC'D BY LOCAL REGISTRAR 5-2-55 | REGISTRAR'S SIGNATURE Mrs. Nancy A. Poe

24. FUNERAL DIRECTOR ADDRESS Joseph R. Durst, Frostburg, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03270

3272

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 57 Years
02
HOSPITAL OR INSTITUTION OR STREET ADDRESS 803. Columbia Ave
00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
02
STREET ADDRESS (If rural give location) 803. Columbia Ave
1

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) H (Last) Smith

4. DATE OF DEATH: (Month) April (Day) 21 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: October 23 1897

9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Western Maryland RR.

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles J. Smith

14. MOTHER'S MAIDEN NAME: Anna Lowery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-10-7825

17. INFORMANT & ADDRESS: Mrs. Olive Smith, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X

IMMEDIATE CAUSE (A) Carcinomatosis

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Carcinoma of right lung DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. , 1954, to Apr. 21, 1955, that I last saw the deceased alive on Apr. 20, 1955, and that death occurred at 1:05 PM, from the causes and on the date stated above.

SIGNATURE Jos. H. Levy Jr. M. D. ADDRESS 456 N. Centre St. DATE SIGNED 4/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF April 24 1955 | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR April 24, 1955 | REGISTRAR'S SIGNATURE Winter K. Brantz, M.D.

24. FUNERAL DIRECTOR ADDRESS William H. Kight · Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03271

3273

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 12/6/51
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg 22
STREET ADDRESS (If rural give location) 158 West Main Street 1

3. NAME OF DECEASED: (Type or Print) (First) Lavina (Middle) (Last) Spitznas

4. DATE OF DEATH: (Month) April (Day) 25, (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: 10/9/1870 | 9. AGE last birthday 84 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Spitznas
14. MOTHER'S MAIDEN NAME: Catherine Doubt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0 IMMEDIATE CAUSE (A) Chronic Myocarditis, — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Cerebral arteriosclerosis, — ?
DUE TO (C) Chronic Hepatitis — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Jaundice, — 6-8 Yrs.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1952 to Apr. 25, 1955, that I last saw the deceased alive on Apr. 24, 1955, and that death occurred at 2:45A M, from the causes and on the date stated above.
SIGNATURE James E. McLean M. D. ADDRESS 49 Green St. DATE SIGNED 4-25-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4/28/55 | NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park | LOCATION (City, town, or county) (State) Frostburg, Maryland

DATE REC'D BY LOCAL REGISTRAR April 26, 1955 | REGISTRAR'S SIGNATURE Winter R. Hauty, M. D. | 24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Maryland ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03272

3287

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg
LENGTH OF STAY (in this place) 5yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 183 W. Mechanic Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg 22
STREET ADDRESS (If rural give location) 183 W. Mechanic St.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Leona (Last) Stapleton

4. DATE OF DEATH: (Month) 4 (Day) 14 (Year) 19 55.

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 9-22-1883

9. AGE last birthday 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Treasury Dept.

10B. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): Vale Summit, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Stapleton

14. MOTHER'S MAIDEN NAME: Margaret Delaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Bernadette Finn, 183 W. Mechanic St. Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) DUE TO Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Coronary Sclerosis — 1 mo ?
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 22, 1955, to Apr 14, 1955, that I last saw the deceased alive on Mar 26, 1955, and that death occurred at 9:10 A M, from the causes and on the date stated above.

SIGNATURE Wm C Lane M. D. ADDRESS Frostburg Md DATE SIGNED Apr 15 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 4-16-55 — NAME OF CEMETERY OR CREMATORY St. Michael's Catholic — LOCATION (City, town or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 4-16-55 — REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR Jacob Hafer, — ADDRESS 23 E. Main, Frostburg, Md.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03273

3293

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cumberland, Rural
LENGTH OF STAY (in this place) 82 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 2, Baltimore Pike

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Rural X
STREET ADDRESS (If rural give location) Route 2, Baltimore Pike 1

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) M. (Last) STEGMAIER

4. DATE OF DEATH: (Month) (Day) (Year) April 17, 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Single	Aug. 14, 1872	82 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Cumberland, Md,	USA

13. FATHER'S NAME: Leonard Stegmaier

14. MOTHER'S MAIDEN NAME: Gertrude Hook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No	None	Anna Stegmaier, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE (A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertensive Cardio-Vascular Disease — 5 yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. malnutrition

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1955, to 17 April 1955, that I last saw the deceased alive on 13 April, 1955, and that death occurred at 8:40 A M, from the causes and on the date stated above.

SIGNATURE James G. Stegmaier M. D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 20 1955	St. Peter & Pauls Cem.	Cumberland, Md,

DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
April 20, 1955	Walter R. Frantz, M.D.	William H. Kight, Cumberland, Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

William [illegible] Hall

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03274

3274

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 12 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1X Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural, give R.F.D.) Washington Lee Apartments 03 South Lee Street 1

3. NAME OF DECEASED: (Type or Print) (First) ANN (Middle) (Last) STRICKLAND
4. DATE OF DEATH: (Month) April (Day) 7 (Year) 19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	September 5 1889	65 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Renova, Pa.	USA

13. FATHER'S NAME: Daniel Healy
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	F. C. Strickland, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)	300.7 [illegible] Schizophrenia	months
ANTECEDENT CAUSE (S) DUE TO (B)	malnutrition,	weeks
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	arteriosclerosis;	months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1955, to April 7, 1955, that I last saw the deceased alive on April 6, 1955, and that death occurred at 12 30 M, from the causes and on the date stated above.

SIGNATURE B. M. Schneider M.D. ADDRESS Grantsville DATE SIGNED 4/7/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 9, 1955	St. Joseph Cemetery	Renova, Pa. Clinton Co.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 7, 1955	Wintes R. Hauk, M.D.	William H. Kight	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits DR. SCHINDLER 3275

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03275

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 27 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPTIAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02
STREET ADDRESS (If rural give location) 26 GREENE STREET 1

3. NAME OF DECEASED: (Type or Print) (First) MAUDE (Middle) (Last) SUTTON

4. DATE OF DEATH: (Month) APRIL (Day) 19, (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: FEB. 10, 1890

9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10B. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES CONDOUR

14. MOTHER'S MAIDEN NAME: CLARA, (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 156-26-6914

17. INFORMANT & ADDRESS: Memorial Hosp. Cumberland Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Auricular Fibrillation — weeks

DUE TO (C) Arteriosclerotic Heart Disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 15, 1955 to April 19, 1955, that I last saw the deceased alive on April 19, 1955, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

SIGNATURE B. M. Schindler ADDRESS M.D. 41 Greene St DATE SIGNED 4/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-22-1955	Rose Hill Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 22, 1955	Winter R. Mauzy, M.D.	Charles L. George	Cumberland, Md.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03276

3276

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 51 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing Maryland X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) John William Sweitzer, Jr.

4. DATE OF DEATH: (Month) (Day) (Year) 4-17-55 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: 12-16-1868

9. AGE last birthday 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10B. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Maryland -Orleans

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wm. Sweitzer

14. MOTHER'S MAIDEN NAME: Shirlett Kear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. [redacted]-10-2576

17. INFORMANT & ADDRESS: Mrs. Hattie Sweitzer

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1777 IMMEDIATE CAUSE (A) Cerebral Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 3d.

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Metastatic Carcinoma. — 6 mo.

DUE TO (C) Carcinoma of the Prostate. — 1 1-2 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12, 1955, to 4-17, 1955, that I last saw the deceased alive on ....., 19..., and that death occurred at M, from the causes and on the date stated above.

SIGNATURE George Richard Jr. M. D. ADDRESS Lonaconing, Md DATE SIGNED 4-17-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 4-21-55

NAME OF CEMETERY OR CREMATORY Haven Memorial

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR April 18, 1955

REGISTRAR'S SIGNATURE Wintes R. Frantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli, ADDRESS Cumberland, Md

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03277

CERTIFICATE OF DEATH

3277

Reg. Dist. No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 3-51

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: 02 Cumberland
LENGTH OF STAY (in this place): 19 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00 703 Louisianna Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland 02
STREET ADDRESS (If rural, give location): 703 Louisianna Ave. 1

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) Francis (Last) Tippen

4. DATE OF DEATH: (Month) 4 (Day) 20 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: Feb. 27, 1905

9. AGE last birthday: 50 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Textile Mill

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-5521

17. INFORMANT & ADDRESS: Mrs. Helen Tippen, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

241X

Immediate cause (a) Coronary occlusion — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Hypertensive Heart Disease — DUE TO — Interval Between Onset and Death: 10 years

(c) Chronic asthmatic Bronchitis — Interval Between Onset and Death: 15 years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.: none

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 3 52, to Apr. 20 55, that I last saw the deceased alive on 4-20-55, and that death occurred at 6.35 P m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

J. Wallenan MD 140 Seybold St. Cumberland Md. 4-22-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 4-25-1955

NAME OF CEMETERY OR CREMATORY: St. Mary's

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: April 24, 1955

REGISTRAR'S SIGNATURE: Walter K. Lantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03278

3278

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 13 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Rural X
STREET ADDRESS (If rural give location) R.F.D. #3. Bedford Road

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) William E. Thom

4. DATE OF DEATH: (Month) (Day) (Year) 4-29-55 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 5-9-93

9. AGE last birthday 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machanist

10B. KIND OF BUSINESS OR INDUSTRY: B. & O. RR

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Thom

14. MOTHER'S MAIDEN NAME: Margaret McBride

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO. 705-05-4819

17. INFORMANT'S ADDRESS Mrs. Helen Thom Wife Route 3, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

163X IMMEDIATE CAUSE (A) Bronchial Obstruction — 3 months

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Carcinomatosis of Peribronchial nodes — 1 year

DUE TO (C) Carcinoma of Lung - right — 1 year

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Post Operative empyema - right — 1 year

19A. DATE OF OPERATION: 1954

19B. MAJOR FINDINGS OF OPERATION: Carcinoma Right Lung with Lymph node metastasis

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19 57, to April 29 1955, that I last saw the deceased alive on April 28, 1955, and that death occurred at 9:00 A.M, from the causes and on the date stated above.

SIGNATURE H. Heinemann M.D. ADDRESS Cumberland DATE SIGNED Md 4/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF May 1 1955 — NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR May 1, 1955 — REGISTRAR'S SIGNATURE Walter L. Fautz, M.D.

24. FUNERAL DIRECTOR ADDRESS William H. Kight, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Himmelright 3294

CERTIFICATE OF DEATH

03279

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital give location) OD Rt. # 4. Oldtown Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland X
STREET ADDRESS (If rural give location) Rt. # 4. Oldtown Road

3. NAME OF DECEASED: (Type or Print) (First) Ehrman (Middle) Elizabeth (Last) Twigg

4. DATE OF DEATH: (Month) Apr. (Day) 10, (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: Jan. 11, 1866

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John D. Ellis

14. MOTHER'S MAIDEN NAME: Theodocia Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. Ira Robinette Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443X IMMEDIATE CAUSE (A) Cerebral Vascular Accident

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) Arteriosclerotic Cardio Vascular Disease

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 4, 1954, to April, 1955, that I last saw the deceased alive on March 30, 1955, and that death occurred at 1:30 P M, from the causes and on the date stated above.

SIGNATURE M. Himmelright M.D. ADDRESS 133 Va Ave Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 4-13-1955

NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: April 12, 1955

REGISTRAR'S SIGNATURE: Wintes R. Kantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

3295

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03280

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCool | LENGTH OF STAY (In this place) 90 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westernport Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCool
STREET ADDRESS (If rural, give location) Westernport Road

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Ervin (Last) Weasenforth
4. DATE OF DEATH: (Month) Apr. (Day) 9, (Year) 1955
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 25, 1883
9. AGE last birthday: 71 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scheer, W. Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Theadore Weasenforth
14. MOTHER'S MAIDEN NAME: Catherine Amtower,
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Charles Ray Weasenforth

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

1637 Immediate cause (a) Carcinoma of Lungs (Metastatic — Jan 1955

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Nephroma - right

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 19 55, to April 9, 19 55, that I last saw the deceased alive on April 9, 19 55, and that death occurred at 1:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

D. L. Griffin MD — Keyser W Va — 4-9-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 4/12/55 | NAME OF CEMETERY OR CREMATORY: Dayton Cemetery | LOCATION (City, town, or county) (State): Near McCool Md.

DATE REC'D BY LOCAL REG. 4-11-55 | REGISTRAR'S SIGNATURE: Mrs Jean C. Kelly | 24. FUNERAL DIRECTOR: B. W. Markwood | ADDRESS: Keyser W. Va

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3279

CERTIFICATE OF DEATH

03281

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hosp 02

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 314 Frederick St

3. NAME OF DECEASED: (Type or Print) (First) Leonard (Middle) Van (Last) Wheeler

4. DATE OF DEATH: (Month) April (Day) 30 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 4/29/55

9. AGE last birthday yrs. — IF UNDER 1 YEAR Months — Days 1 — IF UNDER 24 HRS. Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred Wheeler

14. MOTHER'S MAIDEN NAME: Bessie Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Sacred Heart Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

761.0

IMMEDIATE CAUSE (A) Mal presentation Breech with Fet — DUE TO — INTERVAL BETWEEN ONSET AND DEATH 3 hrs

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Hydramnios — DUE TO

(C) Small body 4 lbs 3 oz

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Difficult Delivery Slow labor 24 hrs

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 29 1955, to April 30 1955, that I last saw the deceased alive on April 30, 1955, and that death occurred at 10 P M, from the causes and on the date stated above.

SIGNATURE F. Allen G. Morrow M.D. ADDRESS Cumberland Md DATE SIGNED May 1-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 5/2/55 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) (State) Cumberland Md

DATE REC'D BY LOCAL REGISTRAR May 2, 1955 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR Davis Stein Inc — ADDRESS Cumberland, Md.

2045364392

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits HODGES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3280 **CERTIFICATE OF DEATH** Reg. Dist. No. 03282 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 3 HR. 6 MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE PENNA. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BREEZEWOOD
STREET ADDRESS (If rural give location) R.F.D. #2

3. NAME OF DECEASED: (Type or Print) (First) ~~BABY~~ Jeffrey (Middle) Lynn (Last) WILT - Twin #2

4. DATE OF DEATH: (Month) APR. (Day) 29 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE

8. DATE OF BIRTH: APRIL 29, 1955

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 3 Min. 6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: VICTOR D. WILT

14. MOTHER'S MAIDEN NAME: NORMA JEAN WINTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

762.5 IMMEDIATE CAUSE (A) DUE TO Prematurity - 2nd of twins

ANTECEDENT CAUSE (S) (B) DUE TO (Repeat section - active labor

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) at 7 1/2 months)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. atelectasis

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/28, 1955, to 4/28, 1955, that I last saw the deceased alive on 4/28, 1955, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE W. Royce Hodges M.D. ADDRESS Cumberland, Md. DATE SIGNED 4/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4/30/1955 | NAME OF CEMETERY OR CREMATORY Mt. Zion Lutheran | LOCATION (City, town, or county) (State) E. Providence Twp., Bed Co., Pa.

DATE RECD BY LOCAL REGISTRAR April 29, 1955 | REGISTRAR'S SIGNATURE Winter R. Trautz, M.D. | 24. FUNERAL DIRECTOR Lynford V. Conner ADDRESS Everett, Pa.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

21452793393

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3281 03283

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 2 days 19 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Rural X
STREET ADDRESS (If rural give location) R.F.D. #3, Bedford Road

3. NAME OF DECEASED: (First) Iva (Middle) Margaret (Last) Zufall (Type or Print)

4. DATE OF DEATH: (Month) 4-28-55 (Day) (Year) 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	4-21-91	64 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Shinnesville, West Va.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Hyle Bennett	Minnie Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
No	None	Peter Zufall, Jr. Rt. 3, Cumberland, Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X IMMEDIATE CAUSE	(A) Cerebral vascular accident	4 days
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (260X)	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Diabetes mellitus	1 year

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-25, 1955, to 4-28, 1955, that I last saw the deceased alive on 4-28, 1955, and that death occurred at 11:00 A M, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
M. D. Roger L. Bacon	Cumberland Md	4-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr. 30, 55	Zion Memorial Park	Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 29, 1955	Winter R. Frantz, M.D.	John J. Hafer	Cumberland, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53